Patient Information

Patient : ___________________________ Age: _______ DOB: ____________

Preferred Pronoun: □ He/Him/His □ She/Her/Hers □ They/Their/Theirs □ Other___

Partner /Spouse: _____________________ Age: _______ DOB: ___________

Preferred Pronoun: □ He/Him/His □ She/Her/Hers □ They/Their/Theirs □ Other___

Street Address: ____

City: ____State: ______ ZIP: _____________

Best Phone Number (Where a private message can be left): ___________________

Alternate Phone Number: __________________ Can we leave a message? Yes / No

Email Address: ____

Can we email you personal medical information (i.e. results, treatment protocols) Yes/ No

Patient Occupation: ____

Employed By: ____

Business Address: ____

Partner/Spouse Occupation: ____

Partner/ Spouse Employed By: ____

Business Address: ____

Partner/Spouse Phone Number: _______________Can we leave a message? Yes / No

Emergency Contact: _______________________________Phone Number: __________________

Relationship: ____

Patient's Social Security Number: _______-_______-_________

Partner's Social Security Number: _______-_______-_________

Name of Insurance Company: ____

Subscriber #: _____________________ Group #: ________________ Contract #: _________________

Your Pharmacy Name: ______________________________ Phone Number: __________________

Purpose of Visit: ____

How did you learn of this practice? □ Friend □ Relative □ Advertisement □ Internet_____________

□ Other: ______________________________

Referring/ Personal Physician Name: ____

Address: ____

Phone Number: _______________________________ Fax Number: _________________________

The undersigned declares that the above information is true and accurate.

____ _______________________________

Signature Date

General Information – Female and/or Oocyte Source

Name: ___________________________________ Preferred to be called by: ______________________
Date of Birth: __________________ Age: ______ Gender: □M □ F □ Other_______________
Sex Assigned at Birth: □M □ F □ Intersex ________
Preferred Pronoun: □ He/Him/His □ She/Her/Hers □ They/Their/Theirs □ Other___
Race (Check all that Apply): □ White □ Black o African American □ Asian
□ Native Hawaiian/Pacific Islander □ American Indian/Alaska Native
□ Other: ___________ □ Prefer Not to Respond

Reproductive and Medical History – Female and/or Oocyte Source

How long have you been trying to conceive? ____
How many years have you been married/together? ____
Please list all pregnancies.

Outcome (Specify live, stillborn, miscarriage or abortion)	Date (Specify delivery date or date pregnancy ended)	Length of Pregnancy (Specify weeks/months)	Father (Specify present or previous spouse/partner)

Have you tried to conceive for longer than a year with another Partner/Spouse? Yes No

Please indicate if you have had any of the following test/procedures performed.

	Yes	No	Date	Results/Outcome
Post-coital				
Basal body temperature				
Endometrial biopsy				
Hysterosalpingogram (HSG)				
Laparoscopy				
Other				

Please explain if needed: ____

Please indicate if you have had any of the following infertility treatments.

	Yes	No	Date	Results/ Outcome
Clomiphene Citrate (Clomid, Serophene)				
Human Chorionic Gonadotropin (HCG)				
Intrauterine Insemination (IUI)				
In-Vitro Fertilization (IVF)				
Frozen Embryo Transfer(FET)				
GIFT/ZIFT				
Intracytoplasmic Sperm Injection (ICSI)				
Donor Insemination				
Other				

Please explain if needed: ____

____

____

Have you ever had any surgeries? (including abortion, ectopic pregnancy, and tubal surgery)?

Type of surgery/Operation	Date	Location surgery took place

Have you ever had any hospitalization other than surgery? If so, please list year, reason, and location hospitalization took place . ____

____

____

Have you ever had any serious illness? If so, please describe. ___________________________________

____

Please indicate if you have ever had any of the following.

	Yes (Specify if currently experiencing or list dates)	No	Unsure
High Blood Pressure			
Heart Disease			
Heart Murmur			
Blood Clots			
Blood Transfusion			
Bleeding Disorder			
Tuberculosis			
Asthma			
Lung Disease			
Hepatitis/ Jaundice			
Epilepsy/ Fits			
Antibiotics during reproductive years			
Syphilis			
Gonorrhea			
Chlamydia			
Pelvic Inflammatory Disease			
Herpes (Oral)			
Herpes (genital)			
AIDS			
Abnormal Pap			
Diabetes			
Thyroid Problems			
Appendicitis/ Appendectomy			
Hernia			
Psychiatric Illness			
Cancer			
Bladder/ Kidney Disease			
Rubella Immunization			
Pulmonary Disease			
Endometriosis			
Exposure to DES (Diethylstilbestrol) at Birth			
Other			

If you answered yes to any of the above, please describe. ____________________________
____
____

Are you currently under a physician's care for any reason not already described? If so, please describe.

____

____

Please list any medications/ treatments you are currently on, including all Vitamins, Herbs, Antacids, Laxatives and/ or pain medications.

Medication / Treatment	Frequency	Reason

Please list any known allergies, including medications, food, and/ or environmental.

____

____

GYNECOLOGICAL HISTORY- FEMALE AND/OR OOCYTE SOURCE

Date last menstrual period started: _______________________ Duration of flow: ______
Age at first period: _______________________ Number of days between each period: ________
Do you experience pain with menses? If so, is it mild, moderate, or severe and what do you use for relief?

____

Do you have pre-menstrual symptoms? If so, please list symptoms. ______________________________

____

Do you have a change in bowel habits with menses? ____
Do you use lubricant with intercourse? ____
Do you douche? If so, how often? ____

Date of last pap smear: ____________________________
Were the results normal? If not, please explain. ___________________________________

____

Do you have a history of abnormal pap smears? If so, please explain and include dates.

____

Please indicate if you have ever used any of the following birth control methods.

	Type	Duration (include dates)

IUD		
Oral Contraceptives		
Diaphragm/ Foam		
Condom		
Other		

Have you ever had any gynecological surgeries? If so, please list year, type of operation, and location surgery took place.

____
____
____

Have you ever had a mammogram? If so, please list date and test results

____
____

ENDOCRINE HISTORY- FEMALE AND/OR OOCYTE SOURCE

Do you experience acne ? If so, when? ____

Please indicate if you experience hair growth in any of the following areas.

	Yes	No
Upper Lip		
Lower Abdomen		
Between Breast		
Around the Rectum		
Chin		
Umbilical		
Nipples		

Do you experience frequent headaches? If so, how often? ___________________________

Height: ___________________________________ Weight: ______________________________

Have you gained or lost weight? If so, how many pounds over what period of time? _______________

____

What is your desired weight? ____

REVIEW OF SYMPTOMS- FEMALE AND/OR OOCYTE SOURCE

Please indicate if you are currently experiencing any of the following symptoms/illnesses.

Vaginal discharge, itching, or burning	_________	Temperature Intolerance	_________
Heartburn, indigestion	_________	Fever, Sweats, Chills	_________
Bleeding or bruising from minor injury	_________	Hot Flashes	_________
Anemia	_________	Excessive Body Hair	_________
Poor circulation, varicose veins	_________	Painful Urination	_________
Eye Problems	_________	Frequent Urination	_________
Frequent Nose Bleeds	_________	Nausea/ Vomiting	_________
Stuffy nose, Sinus trouble, Hay Fever	_________	Gas, Cramps, Pain	_________
Pain in joints, Arthritis	_________	Blood in Stool, Black Stool	_________
Back Pain	_________	Constipation/Diarrhea	_________
Shortness of Breath	________	Hemorrhoids	_________
Dizziness, Fainting	_________	Hernia	_________
Fast or Irregular Heartbeat	_________	Gallbladder Problems	_________
Enlarged or Painful Breast	_________	Dental or Gum Problems	_________
Breast Lumps	_________	Shaking, Tremors	_________
Headaches	_________	Sexual Problems	_________
Depression or Anxiety	_________	Nervousness, Tension	_________
Fatigue	_________	Other _______________________	

If you answered yes to any of the above, please describe.

____

____

____

SOCIAL FACTORS- FEMALE AND/OR OOCYTE SOURCE

Please indicate if you have ever used or practiced any of the following.

	Yes	No	Frequency	Amount	Type	Date Last Used
Tobacco						
Alcohol						
Social Drugs						
Hot Tub/Sauna						
Exercise						

In general, do you handle stress well? Yes No

What would you estimate your average level of stress to be? None Low Moderate High

Have you experienced nay particularly stressful situations with the last six months? If so, please explain.

Specify if due to fertility. ____

____

____

Do you have any theories as to why you and your spouse/partner have not been able to conceive? If so, please explain.

____

____

____

____

FAMILY HISTORY- FEMALE AND/OR OOCYTE SOURCE

Please indicate if anyone in your family, including parents, grandparents, aunts, uncles, brothers or sisters has ever had any of the following.

	Yes	No	Who	What Type	Age Diagnosed/ Deceased Due to Condition
Diabetes					
Cancer					
Heart Disease/ Hypertension					
Serious Birth Defects					
Infertility					

______________________________ ______________________________

Signature Date

GENERAL INFORMATION- MALE AND/OR SPERM SOURCE

Name: ___________________________________ Preferred to be called by: _______________________

Date of Birth: ___________________ Age: ______ Gender: □M □ F □ Other________________

Sex Assigned at Birth: □M □ F □ Intersex ________

Preferred Pronoun: □ He/Him/His □ She/Her/Hers □ They/Their/Theirs □ Other___

Race (Check all that Apply): □ White □ Black o African American □ Asian

□ Native Hawaiian/Pacific Islander □ American Indian/Alaska Native

□ Other: ___________ □ Prefer Not to Respond

REPRODUCTIVE HISTORY – MALE AND/OR SPERM SOURCE

Please list all pregnancies you are responsible for.

Outcome (specify live, stillborn, miscarriages or abortion)	Date (Specify delivery date or date pregnancy ended)	Length of Pregnancy (Specify weeks/months)	Mother (Specify present or previous spouse/partner)

Have you tried to conceive for longer than a year with another partner/spouse? Yes No

How many years have you been married/together? ____

Please indicate if you have had any of the following tests/procedures performed.

	Yes	No	Date	Results/Outcomes
Semen Analysis				
Hamster Sperm Penetration Assay				
Hormone Testing				
Prior fertility Treatment(s)				
Other				

Please explain if needed: ____

Have you ever had any surgeries? If so, list year, type of operation, and location surgery took place.
____
____
____

Have you ever had any hospitalization other than surgery? If so, please list year, reason, and location hospitalization took place . ____
____
____

Have you ever had any serious illness? If so, please describe. _____________________________
____
____

At what age, did you go through puberty? ____

Have you ever seen a urologist? If so, please list date and test results.
____

Please indicate if you have ever had any of the following.

	Yes (Specify if currently experiencing or list dates)	No	Unsure
High Blood Pressure			
Heart Disease			
Heart Murmur			
Blood Clots			
Blood Transfusion			
Bleeding Disorder			
Asthma			
Lung Disease			
Hepatitis/ Jaundice			
Epilepsy			
Antibiotics during reproductive yrs.			
Gonorrhea			
Chlamydia			
Syphilis			
Orchitis			
Mumps			
Prostatitis			
	Yes (Specify if Currently	No	Unsure

	experiencing or list dates)		
Epididymitis			
Hydrocele			
Herpes (oral)			
Herpes (genital)			
AIDS			
Fever Above 101 F. in the past 3 months			
Diabetes			
Thyroid Problems			
Appendicitis/ Appendectomy			
Hernia			
Psychiatric Illness			
Cancer			
Bladder/Kidney Disease			
Rubella Immunization			
Lung Disease			
Exposure to DES (diethylstilbestrol) at Birth			
Other			

If you answered yes to any of the above, please describe. ____________________________

____

____

Do you have any genital or groin injuries? If so, please explain. ________________________

____

____

Are you at risk for AIDS? Yes No

Please list any medications/treatments you are currently on, including all vitamins, Herbs, Antacids, Laxatives and/ or pain medications.

Medications/Treatment	Frequency	Reason

Please list any known allergies, including medications, food, and/ or environmental. ___________

____

Height: ______________________________________ Weight: _________________________________

Have you gained or lost weight? If so, how many pounds over what period of time? ___________

____

REVIEW OF SYMPTOMS- MALE AND/OR SPERM SOURCE

Please indicate if you are currently experiencing any of the following symptoms/illness.

Post-void Dribbling _________

Heartburn, Indigestion _________

Bleeding or bruising from a minor injury _________

Anemia _________

Eye Problems ________

Frequent Nose Bleeds _________

Stuffy Nose, Sinus Trouble, Hay Fever ________

Pain in Joints, Arthritis _________

Back Pain _________

Shortness of Breath _________

Dizziness, Fainting _________

Fast or Irregular Heartbeat _________

Post- Ejaculation Pain _________

Headaches _________

Depression or Anxiety _________

Fatigue _________

Poor circulation, varicose Veins _________

Temperature Intolerance _________

Fever, Sweats, Chills _________

Excessive Body Hair _________

Painful Urination _________

Frequent Urination ______

Waking to Urination (_ times) _________

Gas, Cramps, Pain _________

Blood in stool, Black Stool _________

Nausea/Vomiting _________

Constipation/Diarrhea_________

Hemorrhoids _________

Hernia _________

Gall bladder Problems_________

Dental or Gum Problems _________

Testicular Heaviness _________

Shaking, tremors _________

Sexual Problems _________

Problems Ejaculating _________

Nervousness, Tension _________

Other ________

If you answered yes to any of the above, please describe. __________________________

____

____

ENVIROMENTAL FACTORS- MALE AND/OR SPERM SPOURCE

Have you had any unusual or prolonged exposure to potentially hazardous materials while working or doing hobbies (i.e. radiation, pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium industrial by- products)? If so, Please Explain.

____
____
____

SOCIAL FACTORS- MALE AND/OR SPERM SOURCE

Please indicate if you have ever used or practiced any of the following.

	Yes	No	Frequency	Amount	Type	Date Last Used
Tobacco						
Alcohol						
Social Drugs						
Hot Tub/Sauna						
Exercise						

In general, do you handle stress well? Yes No

What would you estimate your average level of stress to be? None Low Moderate High

Have you experienced any particularly stressful situation with the last six months?
If so, please explain . ____
____
____

Do you have any theories as to why you and your spouse/partner have not been able to conceive? If so, please explain. ____
____
____
____
____

FAMILY HISTORY- MALE AND/OR SPERM SOURCE

Please indicate if anyone in your family, including parents, grandparents, aunts, uncles, brothers or sisters has ever had any of the following.

	Yes	No	Who	What Type	Age Diagnosed/ Deceased Due to Condition
Diabetes					
Cancer					
Heart Disease/ Hypertension					
Serious Birth Defects					
Infertility					

Signature ______________________ Date ______________________

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have questions about this notice, please contact us at (805) 965-3400. This notice describes our privacy practices and that of:

- All employees and office personnel
- Any intern(s), volunteer(s) or student(s) that we allow to input or maintain patient data files
- All internal departments and units of Santa Barbara Fertility Center
- All entities, sites and locations owned by Santa Barbara Fertility Center

Our Commitment to Your Privacy

We are dedicated to assisting you and deeply committed to maintaining your privacy. During the course of your treatment, it will be important for us to discuss and exchange certain personal information about you with other members of your healthcare team. This information is called your Protected Health Information (PHI). Because the individuals of your healthcare team are often at different institutions, we need your permission prior to participating in discussions about you.

Healthcare providers have exchanged this sort of information for years in the practice of medicine. However, in this day of electronic databases, there is concern about how private health information about you is collected and shared. For that reason, the United States Federal Government has issued a regulation to provide safeguards for the privacy and security of health information that may identify you. This rule was issued under a law called the Health Insurance Portability and Accountability Act (HIPAA).

In conducting our business, we may receive, create, use, or disclose individually protected health information regarding you and the services we provide you. We are required by law to provide you with this notice of our legal duties and privacy practices concerning your PHI.

Health Information Security

Santa Barbara Fertility Center requires its employees to follow security policies and procedures that limit access to those employees who need it to perform their job responsibilities. In addition, we maintain physical, administrative and technical measures to safeguard your PHI.

Understanding Your Records

We create a record of the services you receive from Santa Barbara Fertility Center. This record may contain your prescription information and/or correspondence from other healthcare providers. All the information we have about you is called PHI. PHI means health information, including your demographic information, collected from you and created or received by another healthcare provider, a health plan and/or a healthcare clearinghouse.

How We May Use and Disclose Health Information about You

For Treatment: We may use health information about you to provide you assistance with the treatment provided by another healthcare provider. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
For Payment: We may use and disclose health information about you so that the services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations: We may use and disclose your protected health information in order to perform our daily business activities, which may include data management, customer service, complying with laws and quality.
As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.
To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.
For Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
To Maintain Public Health: We may disclose health information about you for public health activities. These activities generally include, but are not limited to the following:

- To prevent or control disease, injury or disability
- To report births or deaths
- To regulate products subject to FDA regulations
- To notify a person who might have been exposed to a disease or might be a risk for getting or spreading a disease or condition
- To report child abuse or neglect
- To notify the appropriate government agency if we think a patient has been the victim of abuse, neglect, or domestic violence

For Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, accrediting or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
For Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
As Information, Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
To Individuals Involved in the Payment of Your Care: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so; or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

Consent
You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but will not apply to any uses and disclosures which occurred before that time. If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of service, payment or health care operations, and we may therefore choose to discontinue providing you service.

Your Rights Regarding Health Information about You
You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy – You have the right to inspect and request a copy of certain health

information we have on file. To inspect and request a copy of health information on file about you, you must submit a written request. If you request a copy of your health information, we may charge you for the costs of copying, mailing, or other associated supplies.

- Right to Request an Amendment – If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information originates at Santa Barbara Fertility Center. You must request an amendment in writing. You must also tell us the reason for your request. The request to amend your record may be denied, in which case you have the right to enter a statement into your record saying that you disagree with the decision.
- Right to Request Restrictions – You have the right to request a restriction or limitation on the health information we use or disclose about you for service, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. You must submit your request for restrictions in writing.
- Right to a Paper Copy of This Notice – You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. This notice is also available on our website, www.santabarbarafertility.com.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will only be made with your written permission or after you have had an opportunity to agree to object. If you provide us with permission to use or share your health information, you may revoke that permission, in writing, at any time. If you revoke, or take away, your permission, we will no longer use or share your health information for the reasons in your written authorization. We will not be able to take back any information that we have already shared.

Changes to this Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have, as well as information we receive in the future.

For More Information or to Report a Problem
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation for filing a complaint.

Effective June 27, 2010, physicians in California must inform their patients that they are licensed by the Medical Board of California, and include the Board’s contact information. As such, please be informed of the following should you wish to obtain more information or file a complaint:

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

ACKNOWLEGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, ____________________________________, have received a copy of Santa Barbara Fertility Center's *Notice of Privacy Practices*.

____ _______________________________

Patient Signature Date

____ _______________________________

SBFC Representative Date

FOR OFFICE USE ONLY

Santa Barbara Fertility Center attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices. Acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barrier prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (please specify) ____

FINANCIAL POLICY

All fees for procedures and treatment are due and payable at the time services are provided.

Monthly statements stating outstanding balances will be sent to all patients. It is your responsibility to maintain a current address on file with our office. Our office accepts payments in the form of cash, personal check, Visa, MasterCard, Discover, and American Express. A $25.00 fee will be charged for all returned checks.

If you are enrolled in a health plan that our office is contracted with, all services that are a covered benefit will be billed directly to your health plan. Your co-pay is due at the time of service. Any treatment that is a non-covered benefit will be due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We bill your insurance plan as a courtesy; however, you are responsible for payment if your insurance company fails to pay. It is your responsibility to be aware of your infertility benefits, as well as medication coverage dispensed through our office.

As described in our Notice of Privacy Practices, please be aware that all medical information is confidential under certain state and federal laws. Such information may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s) and/or your healthcare team.

Assignment of Benefits and Authorization to Release Information

I, ______________________________________, hereby authorize Santa Barbara Fertility Center (SBFC), to acquire from and/or release to my healthcare team and/or my insurance company(ies), any information required for the purposes of healthcare management and/or for processing medical claims on my behalf. I understand that upon acceptance of treatment from SBFC, I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance carrier. I authorize SBFC to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to SBFC. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to SBFC.

____ ______________________________

Patient Signature Date

____ ______________________________

Policy Holder Signature (if different from above) Date

RELEASE OF MEDICAL RECORDS

____
Patient Name

____
Address

____
City ST ZIP

____
Phone

____
Date of Birth

I hereby authorize: ______________________________
Name of Physician or Hospital

____
Address

____
City ST ZIP

____
Phone Fax

To release my complete medical records, information pertaining to my medical history and treatment, including all ultrasound reports, ovarian stimulation flowsheets, operative reports, psychiatric evaluations and laboratory results, including HIV results to:

Santa Barbara Fertility Center
536 E Arrellaga Street, Suite 201
Santa Barbara, CA 93103
Phone (805) 965-3400
Fax (805) 965-1222

I understand I may revoke this consent at anytime except to the extent that action has already been taken on it and that it will expire automatically 90 days from the date below. I may revoke this consent by notifying the above listed facility in writing.

______________________________ ______________________
Patient Signature Date

FREQUENTLY ASKED PRE-CONCEPTUAL QUESTIONS

The following is meant to provide answers to frequently asked questions during the preconceptual period. This information may be useful to you as you undergo fertility treatment. We welcome you to discuss the following issues or any other fertility-related concerns with us.

Lifestyle and environment: Certain lifestyle choices and environmental factors have been shown to influence fertility. Prior to and during fertility treatment, we recommend the following:

- Avoid cigarette smoking (male and female partners)
- Limit alcohol consumption to 4 or fewer drinks per week
- Limit caffeine intake to less than 2 cups a day
- Avoid use of marijuana or any other recreational drugs
- Avoid direct exposure to perchlorethylene (dry cleaning industry), toluene (printing business), ethylene oxide, herbicides, fungicides, pesticides

Exercise*:* If exercise is part of your daily or weekly routine, you may continue to do so as long as it is comfortable. However, there are times during fertility treatment and perhaps during early pregnancy that your doctor will recommend that you refrain from or limit exercise. Specifically, if you are undergoing in vitro fertilization and/or embryo transfer, exercise should be avoided on the day of egg aspiration and through pregnancy test. In addition, if your ovaries are stimulated to make multiple eggs, you may feel uncomfortable with some forms of exercise and should limit it to such exercise as walking, stationary biking, swimming and yoga. We ask that you refrain from inverting your body during stimulation (i.e. upside-down yoga positions, trapeze, gymnastics or any sport that would have your feet higher than your head.

Medications: Many over-the-counter and prescription medications may be taken during fertility treatment. If we prescribe it to you, we believe that it is safe. In addition, the following ***may*** be taken during fertility treatment according to the directions on the bottle (unless you are known to be allergic):

Pain relievers:	Tylenol, regular or extra strength, Tylenol with codeine, Vicodin
Decongestants:	Sudafed, Afrin nose spray, TheraFlu, Tylenol Cold, Benadryl, Claritin, Zyrtec
Cough Medicine:	Robitussin DM, Vicks Formula 44
Antacids:	Tums, Maalox, Milk of Magnesia, Mylanta
Laxatives:	Metamucil, Colace, Citracel
Hemorrhoids:	Tucks, Anusol HC, Witch Hazel
Antibiotics:	Penicillin, Ampicillin, Keflex, Macrobid, Flagyl, Doxycycline
Herbs:	Cranberry, Echinacea
Yeast infections:	Monistat, Gyne-Lotrimin, Diflucan
Aspirin:	Baby Aspirin (if specifically prescribed)

The following medications generally ***should not*** be used during fertility treatment, unless specifically approved or recommended by your doctor:

Pain relievers:	Motrin, Advil, Aleve, full-strength aspirin, non-steroidal anti-inflammatory drugs
Herbs:	Hormonally–active herbs, Black Cohosh, Feverfew, Garlic, Ginseng, St. John's Wort, Goldenseal

Decongestants: Allegra

Recommendations for pre-conceptual counseling for birth defects and genetic disorders: Birth defects are abnormalities which are present at the time of a baby's birth. They occur in approximately 3% of pregnancies. It is possible that you may be at increased risk for certain types of birth defects and therefore may want to consider special counseling and/or testing prior to achieving pregnancy.

1) **Structural birth defects**: When some part of the baby's body did not form correctly or completely, this is a structural birth defect. For example, neural tube defects (e.g. spina bifida, anencephaly) result when the coverings over the spinal cord or brain do not close properly. The folic acid in your prenatal vitamins can help prevent neural tube defects, but must be taken before pregnancy (that is, while you are attempting to conceive) and in early pregnancy to be effective. There is no single cause of structural defects, but certain medical conditions such as diabetes can be associated with a higher risk.
2) **Intracytoplasmic sperm injection (ICSI):** For men who have very low sperm counts and require ICSI, we recommend that further genetic testing be done, including a test to count the number of chromosomes (karyotype), and a specific test to look at the male chromosome (Y chromosome deletion). There have been reports of infertility in male children born after ICSI using sperm of men with severely decreased sperm counts.
3) **Birth defects due to infection:** If certain infections are acquired by the mother during pregnancy, they can cause abnormalities in the baby. Rubella (German measles) and varicella (chickenpox) are two examples. If you have not already had these diseases or been vaccinated, you should be vaccinated at least one month before becoming pregnant.
4) **Prenatal Screening for Genetic Disorders**: It is possible that you are unknowingly a carrier of a genetic disorder that could be passed on to your offspring. Some inheritable diseases are more common among individuals of certain ethnicities. For example:
    - African-American: Sickle cell
    - Caucasian: Cystic Fibrosis
    - Ashkenazi Jewish: Tay-Sachs, Cystic Fibrosis, Familial Dysautonomia, Fanconi
    - Asian: Thalassemia

Blood tests can be performed either before conception (pre-conceptual) or early in pregnancy to find out whether either parent is a carrier of certain genetic defects that could affect the health of the baby. If you fall into one of the above ethnic categories, you may want to consider pre-conceptual testing.

I, ____, have read and understand the above information.

____ ________________________________

Patient Signature Date

____ ________________________________

SBFC Representative Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, that claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ______________________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ____________________________________ ____________
Physician's or Authorized Representative's Signature   Date

____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: ____________________________________ ____________
Patient's or Patient Representative's Signature   Date

By: ____________________________________
Print Patient's Name

____
If Representative, Print Name and Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.